THE TREATMENT OF DEPERSONALIZATION*

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DEPERSONALIZATION is a state of the personality in which the individual feels changed in comparison to his former state. This change extends to both the awareness of the self and of the outer world and the individual does not acknowledge himself as a personality. His actions seem automatic to him; he observes his own actions like a spectator. The outer world seems strange to him and has lost its character of reality. We find, therefore, in this picture changes of the self, or depersonalization in the narrower sense, and changes in the environment, or feelings of unreality, alienation of the outward world, "Entfremdung der Wahrnehmungswelt." For this latter phenomena, Mapother, Mayer-Gross,[1] Guttmann and Maclay[2] have suggested the term, derealization. Pictures of this type occur according to my own studies,[3] Haug[4] and Mayer-Gross[1] in a great variety of clinical conditions. The picture has been observed as a passing phenomenon combined with *déja vu* in the normal. It may appear in connection with organic diseases of the brain, especially before and after epileptic attacks. It has been observed in depressive psychoses and schizophrenia. In the beginning and in the phase of disappearance of severe neuroses it is not uncommon.

However, this picture occurs also as the dominant symptomatology of a very severe and chronic type of a specific neurosis. Patients of this type complain year after year about their changed experience concerning the self and the world. Cases are on record with a duration of twenty or thirty years. This study deals merely with this nuclear group, the neurosis depersonalization.

The philosophical and psychological interest which these cases offer is considerable. Taine[5] was the first to use the picture as proof for his philosophical theories of perception. Besides the complaints of changes in perception and emotions there are complaints concerning the experi-

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ence of one's own body and about changes in the perception of time and space. Accordingly, the philosophers have used every one of these complaints as proof that this particular function is the most important one in our relation to self, body and world.

The picture of depersonalization has also attracted the attention of psychoanalysts, among whom I may mention Sadger,[6] Nunberg,[7] Reik,[8] Federn,[9] Oberndorf,[10] Bergler and Eidelberg.[11]

The various authors have stressed different sides of the psychological problems. Reik stresses the constant self observation which according to his opinion is based on sadomasochistic attitudes. Oberndorf puts the main emphasis on the erotization of thought and especially upon the wish to adopt the way of thinking of the opposite sex. Other authors stress the exhibitionistic and voyeuristic components in the picture. Bergler and Eidelberg are of the opinion that there is a strong tendency to anal exhibition. This exhibition is transformed into an increased tendency to self observation. I am inclined to stress the fact that the patient with depersonalization has been admired very much by the parents for his intellectual and physical gifts. A great amount of admiration and erotic interest had been spent upon the child. He expects that this erotic inflow should be continuous. The final outcome of such an attitude by the parents will not be different from the outcome of an attitude of neglect. Dissatisfaction has to ensue even if the parents live in a state of continual admiration of the child since every such relation does not consider the child as a total human being but merely as a show piece. The dissatisfaction and deprivation of the child has to express itself in an increase of aggressive and submissive tendencies. These combine with sexual tendencies to sadomasochism. Finally, by identification with the parents, self observation will take the place of the observation by others. The self observation will be blended with sadomasochistic tendencies. The individual will at first be able to admire his body as well as his thinking. Since such a detachment from the love object cannot remain satisfactory, the self adulation will be followed by hypochondriac signs. To the denial of vision in the sphere of perception is now added the loss of admiration of one's self. The individual, however, does not completely give up and will at least enjoy the self observation which represents the sadistic components as well as the voyeuristic and narcissistic (self-admiring) ones. The patients, furthermore, preserve their intellectuality in this way and are able to continue their activities in the social and physical world which

may appear outwardly successful although empty of emotional satisfaction for the individual. Depersonalization is the neurosis of the good looking and intelligent who want too much admiration.

It is understandable that a neurosis of such depth will need a psychotherapy of long duration. The best observers in this field agree on this point. Oberndorf, for instance, has treated his cases for a long time and Bergler and Eidelberg write as follows: "We think that this absolute pessimism (concerning the treatment) is not justified; however, it is a prerequisite for the therapy that one knows the mechanisms and starts on the right point. Furthermore, very long time is necessary. While the analysis of a more severe case of obsession neurosis takes at least two to two and one-half years, the double space of time is the requirement for the treatment of depersonalization. It does not seem to be very hopeful if one demands half a decennium for a treatment. However, '*amicus Plato, magis amica veritas.*' " The experiences of Oberndorf and myself are, however, better. Some of my cases were treated with individual psychoanalysis, some of them were treated in group psychotherapy. Two cases may be mentioned shortly.

Rose H. came for treatment at the age of twenty-five with depersonalization symptoms which had existed for two years. She was good looking and of superior intelligence. As so often occurs, the symptoms had suddenly started during an episode of petting in which she had felt that she had lost herself and her emotions. Her sexual feelings also vanished suddenly. This episode had followed an incomplete and disappointing love affair with her employer. The final rejection by him had revived the humiliations she had experienced in early childhood from her father. The psychological treatment led to a recovery after two years. The symptoms disappeared completely; however, one year after the treatment, the patient had not yet made a sexual adaptation.

Gertrude W. came for treatment at the age of twenty-one. Depersonalization symptoms had persisted for several years. She complained "that things were moving up and down before her eyes." "I feel my head is empty. There is only a blank inside. . . . It is as if I would be asleep all the time. I do not realize how time passes. My whole intelligence and personality have disappeared. I have no desires anymore. I might as well be dead. . . . My voice has changed completely. Sensations are present but they do not reach my head." The patient had also a wealth of hypochondriac sensations which pertained particularly to her abdomen. She

was very much concerned about her anal functions. A great hostility concerning the mother reached back into early childhood. There were very lively sadomasochistic phantasies since the age of five. The patient was treated with group psychotherapy and lost almost all her symptoms; however, in this case, also, no sexual adaptation was reached.

Three other depersonalization cases were treated by L. Bender with good results. However, several years later all three cases relapsed under difficult outward situations. In one of my cases no therapeutic result was achieved in three months and the patient discontinued the treatment. In two cases psychotherapy resulted in minor gains. These cases will be mentioned later in another connection.

We may summarize by saying that psychotherapy in depersonalization cases takes a great amount of time, is technically difficult, does not always remove all problems and does not protect the patient from relapses. However, there is no question that every case of depersonalization needs a great amount of psychological help, and there is no reason to be pessimistic concerning psychotherapy in these cases. The treatment has to be psychoanalytic or has to utilize psychoanalytic insight.

Considering the difficulties of the psychotherapeutic approach, one might ask what could be done for these patients by medication. I have occasionally tried benzedrine in depersonalization cases; however, the results were passing and the psychotherapeutic approach was in no way helped by the medication. Guttmann and Maclay[2] have studied the influence of mescaline on depersonalization symptoms insofar as they consist of changes of the surroundings (derealization) but not of the self. However, this improvement was of short duration, not lasting longer than one day. The authors come to the conclusion that it may be used as an adjuvant for psychotherapeutic activity. A drug which brings a relief of short duration is obviously not of a great therapeutic value with such chronic problems. It is usually not very helpful in psychotherapy when one proves to the patient by the temporary relief with drugs, that he can feel better. Drugs which allow the patient to come to a deeper insight by increasing the transference situation and changing the state of consciousness help the psychotherapeutic approach much more than drugs which merely relieve symptoms. Sodium amytal may act in such a way. It has not been tried in depersonalization cases. I have, myself, tried to use benzedrine[12] as a help in revealing psychotherapy of neuroses. However, as mentioned above, such results were not achieved in depersonalization cases.

The modern methods of treatment for schizophrenia have only been tried occasionally in severe neuroses. Glueck[13] mentions in one of his publications a case of severe obsession neurosis which improved by insulin treatment. In the series of cases treated in Bellevue, one case of severe obsession neurosis reacted only temporarily to the treatment. At Bellevue we generally found the application of metrazol therapy simpler from a technical point of view[14] and decided, therefore, to make an attempt to treat this particular type of neurosis with metrazol. The depersonalization cases constitute a comparatively well defined group of neuroses. The psychotherapeutic approach to these cases is difficult. Results obtained in such a group with metrazol might be of use in evaluating the treatment for neurosis in general. We have followed the technique of Meduna[15] and use a 10 per cent aqueous metrazol solution. Injections were given intravenously in doses varying from 4½ to 15 grains. We tried to produce three convulsions in a week. One case may be reported in a short abstract, as an example.

Johanna L., thirty-one years old, comes from a family in which the father and one aunt had severe psychotic states probably of manic-depressive character. She was always considered an outgoing personality. Also her brothers and sisters were energetic and successful. She was the oldest of five children, three girls and two boys. She had two children, one of whom was only a few months old when the patient got sick. The family was at that time in straitened financial circumstances. The illness started five months before admission to Bellevue Hospital. She complained that she always felt too tired and was disinclined to sexual intercourse. She ate very little and claimed that she had lost her sense of taste. She thought this was as a result of a cold. She became untidy in appearance and was preoccupied with the care of her children. She complained that she had lost interest in things; that she didn't belong to this world and that she couldn't cry. She was sent to a sanitarium. There she stated that she was not alive but had turned to stone and had no feelings and no emotions. In the sanitarium she swallowed several needles with suicidal intent, and was, therefore, sent to Bellevue Hospital, on September 10. She said: "I can't live, I don't feel at all, I just got fear of life, everything became complicated, everything turned in me, the whole world just looks flat. Nobody can help me. It feels as if I had no place on earth; nothing in the world belongs to me; I don't feel that my family and children belong to me; life has been taken out of me; I seem to be inside out.

Everything looks backward; the heart doesn't seem to be in the same place; I can't change; just like a chair over there. It is as if the eyes would look inside instead of out. Time neither passes nor stands still. It doesn't seem like another day; there is no penetration of enjoyment. My mind goes round and round all the time in circles; the whole world looks flat to me. I know what torture you and everyone else is going through but no torture is greater than my misery." On the ward she was seclusive and did not talk spontaneously. However, she was very productive when one talked with her. On one occasion, she tried to grab iodine in order to drink it.

On October 4th, metrazol treatment was instituted. She received 4½ grains intravenously and had no convulsion. From then on, up to the seventh of November, fifteen convulsions were produced; the first four with injections of 6 grains, the subsequent three with 7½ grains and the last eight with 9 grains. There were no particular incidents during the treatment. The improvement started after the third convulsion and progressed steadily. The clinical symptoms had practically disappeared after the tenth injection. The patient was discharged fully recovered and with full insight, but she still receives psychotherapeutic help.

We have treated nine cases so far. Table I shows the most important features of these cases. The patients were treated in the hospital with the exception of two who were treated in the out-patient department. These two patients, however, could not be induced to have more than three convulsions. They felt improved but experienced a sensation before the convulsion so terrifying that they did not want to continue voluntarily. We have had the same experience in other patients whom we tried to treat in the out-patient department. We have discussed all the details of the treatment, not only with the patients, but also with the relatives and treated only those patients who could themselves be convinced that the treatment might be effective. There were no untoward incidents in the treatment, except that one patient dislocated his shoulder, but the effects of this had disappeared in a few days.

Not much has to be added to this table. Everyone who has worked with depersonalization cases will agree that the results surpass the results reached by other methods. One may doubt the diagnosis in the one or the other case, for instance, in the case in which emotional flatness is noted. This case was diagnosed by others as one of schizophrenia. The borderline between endogenous depression and depersonalization may be

TABLE I

NINE CASES OF DEPERSONALIZATION TREATED WITH METRAZOL

Name	*Age*	*Additional Symptoms*	*Duration Before Treatment*	*Previous Psycho-therapy*	*Number of Con-vulsions*	*Maxi-mal Dose in Grs.*	*Result*
J. L.	31	Suicidal attempts Severely depressed	5 months	Incomplete	15	9	Cured
R. O.	29	Slight residual signs of previous encepha-litis	Several weeks	None	9	9	Cured
L. R.	31	Severe psychological conflicts for years	4 months	Incomplete	10	15	Much improved
S. H.	30	Neurotic conflicts preceding suicidal at-tempts	1 year	Incomplete	7	7½	Improved
B. A.	19	Catatonic pupils	3 months	None	8	13½	Cured
S. S.	32		4 years	Moderate improvement	3	10½	Further but still incomplete improvement
S. R.	18	Hears his own voice continually as obses-sion	15 months	None	25	12	Improved
W. T.	23	Flatness of emotions	4 years	Incomplete	22	10½	Slightly improved
A. S.	26		4 years	Partly suc-cessful	3	10½	Further but still incomplete improvement

sometimes difficult to draw. However, these diagnostic difficulties lie in the nature of the subject.

It is obvious that insulin and metrazol treatment have a field of application also outside of the field of schizophrenia. They have been variously tried in manic-depressive psychoses. My own experience with the metrazol treatment of manic depressives is too small; however, there were startling results in two cases of confused mania (the only ones treated). I have also observed improvements in depressions. Bennett[16] reports that ten consecutive severe depressive psychotic patients have all been relieved by shock therapy. He reports that the improvement started two weeks

after the treatment began. He also quotes literature which asserts that hysteria and anxiety cases derived benefit from metrazol treatment insofar as the patients established a better *rapport* for psychotherapy after its use.

In most of our cases the first signs of improvement appeared after the first three or four injections, and in the majority of cases the symptoms disappeared after about six to ten injections. We find it advisable, however, to give two or three more injections after the symptoms have cleared up. The symptoms may disappear without further psychotherapy; even then, the individuals always have unsolved psychological problems. I am, therefore, of the opinion that every depersonalization case which is treated with metrazol needs extensive psychotherapy even after he is free from manifest symptoms. We have acted accordingly in all cases in which the outward circumstances made the application of psychotherapy possible. This is the same point of view which Orenstein and myself[17] have taken in respect to insulin and metrazol treatment of schizophrenia.

One may, of course, raise the question whether the results of this treatment of depersonalization are merely due to psychological factors connected with the treatment. The patient experiences indeed terror and fright and even a threat of death. The transference is increased when he regains consciousness. However, it seems to me that such psychological phenomena are obviously the reflection of deep-lying changes in the organic functions. Furthermore, experience shows that deep-lying neurotic pictures cannot be influenced by mere fright. I am, therefore, of the opinion that organic changes in the brain function connected with metrazol treatment have a therapeutic effect on the depersonalization neurosis. It is not possible to say at the present time whether one can generalize this statement for other neurotic conditions. It is even too early to state that the cure in depersonalization cases and in manic-depressive psychosis and schizophrenia will be a lasting one. However, one of my recovered depersonalization cases is free from symptoms and has worked steadily for more than ten months.

Summary and Conclusions

1. The picture of depersonalization is a rather well circumscribed chronic neurotic picture which offers great difficulties for psychotherapy. However by psychoanalysis or methods akin to psychoanalysis good

results can be obtained if the treatment is continued for years.

2. Treatment with mescaline and benzedrine is ineffective.

3. Nine cases are reported in which the intravenous treatment with metrazol in doses sufficient to give convulsions, gave good results. However, some of the cases were not completely cured.

4. This treatment should be combined with psychotherapy.

5. The effects of treatment are probably due to organic changes. The psychological effects of the drug treatment are not sufficient to explain the results.

6. Metrazol treatment is not only effective in schizophrenia but also in manic-depressive pyschoses and in specific types of chronic neuroses. The question arises whether other types of so-called psychogenic disturbance (neurosis) will be responsive to this treatment.

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